PRINTED: 04/28/2011

DEPARTMENT	T OF HEALTH AND HUN	IAN SERVICES				FO	RM APPROVED
CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155702	B. WIN	G		04/07/2	2011
NAME OF I	PROVIDER OR SUPPLIEF	- {	-	1	ADDRESS, CITY, STATE, ZIP CODE		
CARINO	LIANDO LICALTILO	NADE OFNITED		1	MATADOR ST		
	HANDS HEALTH C				IN46970		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F0000	REGELITORI OR	LEGE IDENTIF THAT HAT ORGANIZATION)		1710			DATE
1.0000	l						
		r the Investigation of	FC	0000	The following plan of correction any corrective action set forth	n or	
	Complaint #IN0	0087748.			herein does not constitute an		
		000=10 01 1			admission or agreement by		
	1 ^	0087748- Substantiated,			Caring Hands Health Care Ce	enter	
	Federal/State deficiencies related to the				of the facts alleged or the conclusions set forth in the		
	allegations are c	ited at F152 and F250.			statement of deficiencies. The	Э	
					Plan of Correction and correct	tive	
	Unrelated defici	encies cited.			action are prepared and exec		
					solely as provisions of Federa and State law. Caring Hands	l.	
	Survey dates: A	pril 6 & 7, 2011			Health Care Center requests	that	
					this plan of correction be		
	Facility number:				considered the facilities credit	ole	
	Provider number				allegation of compliance. Completion Date: 05/07/2011		
	AIM number: 2	00386750			Completion Date: 03/07/2011		
	_						
	Survey team:						
	Honey Kuhn, Ri	N, TC					
	Census bed type	•					
	SNF: 3						
	SNF/NF: 79						
	Total: 82						
	Census payor ty	pe:					
	Medicare: 14						
	Medicaid: 49		1		I		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

These deficiencies also reflect State

19

82

Other: Total:

Sample: 3

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WG2Q11

Facility ID:

003130

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155702	B. WING			04/07/20	011
	PROVIDER OR SUPPLIER			1850 M	ADDRESS, CITY, STATE, ZIP CODE ATADOR ST IN46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	•	DATE
	16.2.	accordance with 410 IAC ompleted on April 11,					
	2011 by Bev Fau	• •					
F0152	court of competen the resident are ex	sident adjudged r the laws of a State by a t jurisdiction, the rights of xercised by the person state law to act on the					
	judged incompete legal surrogate de	sident who has not been not by the State court, any signated in accordance with ercise the resident's rights to d by State law.					
SS=D	Based on recinterviews, to address issue future medicular transfusions addressed for of a physicial resident's PC Attorney) on convictions of deficiency expressions revisions residents revisions revision re	cord review and the facility failed to the facility failed to the soft current and the care for blood was thoroughly the lowing the refusal the sorder by the DA (Power of the religious of the POA. This offected 1 of 3 tiewed in a sample is requiring blood	F01	.52	I. Corrective Actions taken for those residents affected by the alleged deficient practice: Resident E: The facility administrative staff conducted phone conference with legal counsel on April 12, 2011 for guidance on this issue. Upon review of all prior POA/Guardianship paperwork was determined that none wer currently in effect. Thus, Carir Hands must follow Indiana law define those individuals who a authorized to consent to health care for Resident E. A letter w formulated and mailed to both daughters involved. A phone message was left with both, appraising them of the immine arrival of this communication. The individual who is named in	a, it ree re	05/07/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155702	A. BUII		00	04/07/2011
		100702	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/01/2011
NAME OF F	PROVIDER OR SUPPLIER				ATADOR ST	
	HANDS HEALTH C	ARE CENTER		1	IN46970	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG	`	
	The records were reviewed 8:45 a.m. Readmitted to to 08/01/06 with including, but seizures, hydrogen dysphasia (decords).	of Resident "E" ed on 04/07/11 at esident "E" was he facility on h diagnoses at not limited to, lrocephalus, ifficulty head injury, and			the power-of-attorney and hea care representative appointme is qualified under Indiana law tonsent to or withhold consent health care for this resident. Tfacility could not take a position opposition to the health care representative, regardless of whether the facility agreed with that decision. II. Identification and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: a) a resident records will be audited for any obvious conflict in determination of who will be the consenting party for health card decisions. III. Measures take and systemic changes made to ensure the alleged deficient practice does not recur: a) Up admission all residents guardianship / POA status will determined and paperwork reviewed by Social Service. If	ent o o o o o o o o o o o o o o o o o o o
	Resident "E"	had been			obvious discrepancies exist, a meeting will be held with family	,
		equently for low			and resident, and/or legal cour to determine proper guidance.	
	hemoglobin	(the iron			the facility will require resident	s
	containing p	igment of the red			and families to appoint a surrogate to make health care	
		hat carries oxygen			determinations. b) Upon know	
		gs to body tissues.)			changes in guardianship / PO/ status, meetings will be called	4
	^3	,			with resident and family; and/o	
	,	nplete Blood			legal counsel to determine who may give consent when reside	
	Count) done	on 02/23/11,			are unable to do so. And, a	1110
	indicated a F	Igb (Hemoglobin)			surrogate decision-maker will lidentified. IV. How the correct	

		(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	
		155702	B. WING			04/07/2	U11
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CARING	HANDS HEALTH C	ARE CENTER			ATADOR ST IN46970		
(X4) ID		TATEMENT OF DEFICIENCIES		D I			(Y5)
PREFIX		CY MUST BE PERCEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
!	of 7.5 with a	reference range		ĺ	actions will be monitored and t QA system implemented to	he	
	(normal rang	ge) of 14.0-18.0. A			ensure the alleged deficient practice does not recur: a)		
	physician's c	order, dated			Social Service will audit reside	nt	
	02/23/11, ind	dicated, "Transfuse			guardianship/POA documents a quarterly basis (in coordination		
	2 units PRB	Cs (Packed Red			with Care Plan meetings) to		
	Blood Cells)	; may do in a.m"			discover any obvious changes status and to address timely w families and/or other agencies	ith	
	Review of N	Jurse's Notes			b) Social Service will report monthly to the QA committee t results of this audit for further		
	indicated:				action by administration and/or	r	
	"02/23/11 11	25 (11:25 a.m.)			legal counsel as necessary.		
	Res (POA#1	l name) called &					
	`	mission for res					
	•	have consult c					
	· ´						
	(with) a surg	;COII					
	02/23/11 113	30 (11:30 a.m.)					
	Also res (PC	OA #1) stated if res					
	`	ery he could not					
	_	I transfusion.					
	_	ainst her (POA # 1)					
	religion"						
	 02/23/11 6·4	-5 p.m.,(.POA #2					
		ed-she stated OK.					
		cu-sne stated OIX.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIF A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED	
	PROVIDER OR SUPPLIER		18	50 MA	DDRESS, CITY, STATE, ZIP CODE ATADOR ST N46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	02/24/11 123	30 (12:30 p.m.)					
	Resident sen	t to (ACF: Acute					
	Care Facility	r: hospital) r/t					
	(related to) l	ow Hgb of 7.5.					
	Res is to rec	eive 2 units PRBC.					
	(POA #2 nar	ne) notified. She					
	stated "OK &	& thank you" & to					
	please notify	here (sic) when					
	res returns to	facility					
	Received NO D/C (disconto) (at) this x #1) request. Nursing) not 02/24/11 160 Spoke c residual (at) r/t her de 160 Spoke c	20 (3:20 p.m.) O (New Order) to tinue) transfusion (time) per (POA DON (Director of tified. 20 (4:00 p.m.) dent's POA (name ecision to stop usion @ this time.					
	(POA #1) is & God woul	ne) states that she a Jehovah Witness d not want her et a transfusion.					

003130

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155702	A. BUII B. WIN			04/07/2011
NAME OF F	PROVIDER OR SUPPLIER				ATAROD ST	
CARING	HANDS HEALTH C	ARE CENTER			ATADOR ST IN46970	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
	(POA #1) sta	ates that she is the				
	only person	to make decisions				
	for resident	& she does not				
	want (POA #	#2) influencing any				
	decisions					
	02/25/11 10:	30 a.m. Contacted				
	(POA #1)	have been told by				
	mother (nam	ne) & (POA #2) that				
	resident had	always been				
	Baptist(Po	OA #1) stated she				
	is the Jehova	h Witness, did not				
	deny or conf	firm that resident is				
	Baptist just s	stated he had been				
	to "meetings	, "				
	beforeDis	cussed with (POA				
	#1) that deci	sions for resident				
	should act in	his best interest &				
	based on his	belief system"				
	A CBC done	e on 03/10/11,				
		Igb of 7.0. A				
	physician's c	order, dated				
	03/10/11, ind	dicated, "Transfuse				
	2 units PRB	C's (Packed Red				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WG2Q11 Facility ID:

003130

If continuation sheet

Page 6 of 44

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
111,12 1 2.11.	or condition	155702	A. BUII B. WIN			04/07/2011
NAME OF F	PROVIDER OR SUPPLIER		P. (12.)		ADDRESS, CITY, STATE, ZIP CODE	
	HANDS HEALTH C			1	ATADOR ST IN46970	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	1140970	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	Blood Cells))"				
	Review of N	lurses Notes				
	indicated:					
	 "02/11/11 10)20 (7:20 n m)				
		930 (7:30 p.m.)				
	_	or 03/11/11 @ 1645				
	(4:45 p.m.).					
		ordered if POA				
		ll consent for				
	^	POA contacted by				
		nd Social Services				
	`	OA #1 name)				
		the lab value &				
	•	resident's status.				
	POA was in					
		demonstrated				
		ondition. Resident				
	is noted to h	ave pale skin				
	color/nailbed	ds, increase fatigue,				
	often reuses	to get OOB (out of				
	bed) & refus	es mealsPOA				
	verbalizes ui	nderstanding of the				
	Hgb as well	as the decline in				
	condition. P	OA continues to				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WG2Q11 Facility ID:

003130 If continuation sheet Page 7 of 44

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		INSTRUCTION 00	(X3) DATE S COMPLI		
		155702	A. BUI B. WIN	LDING IG		04/07/20)11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CARING	HANDS HEALTH C	ARE CENTER		1	ATADOR ST IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	refuse the bl	ood transfusion r/t					
	religious bel	iefs. POA did					
	agree to com	ne in to facility this					
	week to asse	ess resident & talk c					
	administrativ	ve staff"					
	Review of S	ocial Service notes					
	indicated an	entry on 01/27/11.					
	The next ent	ry indicated:					
	"03/09/11 ID	PΤ					
	(Interdiscipli	inary Team: a team					
	composed of	f staff from various					
	departments	to address resident					
	needs) care p	olan meeting held.					
	Resident and	I family invited but					
	not in attend	ance. He					
	continues D	NR (Do Not					
	Resuscitate:	no life saving					
	measures in	event of heart or					
	breathing sto	oppage) code status					
	c Advance D	Directives in place					
	in chart. His	s POA is his sister					
	(name of PO	A#1). Care plans,					
	,	made @ this time."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155702	B. WIN			04/07/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CARING	HANDS HEALTH C	ARE CENTER		1	IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
TAG	"03/22/11 Be received on 0 03/21/11 @ down, depression when getting resident kept him. Staff to and behaviors." "03/23/11 SS Designee) lost finding docus (HCP) (Heal Attorney) to and (POA #2 from resident Both (POA notified any (sic) c forms concerns."	ehavior report 03/22/11, dated resident feeling ssed & hopeless. g ready for bed, t asking staff to kill alked to resident r stopped." SD (Social Service ooking in overflow aments giving POA th Care Power of (POA #1 name) 2 name) secondary tts mother (name). #1) and (POA #2) (sic) in agreeance sno further		TAG			DATE

003130

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155702	A. BUI B. WIN	LDING IG		04/07/2	011
NAME OF I	PROVIDER OR SUPPLIER		-!		DDRESS, CITY, STATE, ZIP CODE	!	
CARING	HANDS HEALTH C	ARE CENTER			ATADOR ST IN46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		ealth Care Power of	+	IAG			DATE
		orms signed on					
	05/05/06, pr	•					
		f Resident "E" to					
		The document					
	_	It is my desire to					
	·	opriate medical					
		long as there is a					
		ope of recovery,"					
		vere signed by POA					
		ry and POA #2 as					
	secondary H	lealth Care Agents.					
	Interview wi	ith the Corporate					
	RN, on 04/0	7/11 at 11:30 a.m.,					
	indicated Re	esident "E" had a					
	Hgb of 7.6 c	on 04/07/11 and an					
	order for tra	nsfusion if Hgb					
	dropped to 7	7.5 or lower. The					
	Corporate R	N indicated there					
	was no resol	ution in regards to					
	the issue of l	POA #1's religious					
	beliefs and t	he issue would					
	again need to	o be addressed.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155702	B. WIN			04/07/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST		
CARING	HANDS HEALTH C	ARE CENTER		1	IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Interview wi	ith the					
	Administrate	or, on 04/07/11, at					
	11:00 a.m., i	ndicated he was					
	involved wit	th the issues and					
	the facility h	ad met with POA					
	#1 but had n	ot documented the					
	meeting. Th	e Administrator					
	indicated the	e mother of					
	Resident "E'	' is the guardian of					
	the resident.	The mother of					
	Resident "E'	' has since declined					
	and is now h	erself a resident in					
	the facility a	nd not					
	interviewabl	e. The					
	Administrate	or further indicated					
	there was dis	sagreement					
	between PO	A #1 and POA #2					
	in regards to	blood					
	administration	on for Resident					
	\parallel "E". The Ac	lministrator					
	indicated PC	OA #2 wanted					
	Resident "E'	' to receive the					
	blood transfi	usion as it was not					
	against the r	eligious beliefs the					
	resident was	raised with. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/07/2011
	PROVIDER OR SUPPLIER		1850 M	ADDRESS, CITY, STATE, ZIP CODE ATADOR ST IN46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Administrato	or indicated during			
	discussion of	f family issues			
	with POA #2	2 he "cannot use			
	my nurses st	ation as a			
	battleground				
	Administrato	or indicated there			
	was no docu	mentation in			
	_	facility addressing			
	the medical issues and the				
	_	abiding by the			
	wishes of PO	OA #1.			
	This Federal	Tag relates to			
	Complaint #	IN00087748.			
	3.1-3(c)				
F0250	social services to a highest practicable psychosocial well-	orovide medically-related attain or maintain the e physical, mental, and being of each resident.	F0250	Corrective actions taken for	05/07/2011
JU-0		cord review and	1.0230	those residents affected by the	03/07/2011
	· ·	he facility failed to dent's need for a		alleged deficient practice: Resident E: The facility administrative staff conducted	а

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155702	B. WIN			04/07/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			1850 M	IATADOR ST	
CARING	HANDS HEALTH C	ARE CENTER			IN46970	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	blood transfi	LSC IDENTIFYING INFORMATION)		TAG	phone conference with legal	DATE
					counsel on April 12, 2011 for	
	thoroughly addressed following				guidance on this issue. Upon review of all prior	
	the refusal o	f a physician's			guardianship/POA paperwork,	it
	order by the	resident's POA			was determined that none wer currently in effect. Thus, Carir	
	(Power of A	ttorney) on the			Hands must follow Indiana law	to
	religious convictions of the				define those individuals who a authorized to consent to healtl	l l
	POA. This	deficiency effected			care for Resident E. A letter v	
	1 of 3 residents reviewed in a				formulated and mailed to both daughters involved. A phone	
					message was left with both	
	•	residents requiring			appraising them of the immine	ent
	blood transfi	usions. (Resident			arrival of this communication. Regardless, the survey	
	"E")				allegations on their face do no	t
	,				demonstrate that Caring Hand	s
	 Einding incl	udag:			did not provide necessary and appropriate Social Services to	
	Finding incl	uues.			this resident especially in light	
					the fact that the facility followe	d
	The records	of Resident "E"			the decision of the appointed health care representative. Al	so
	were review	ed on 04/07/11 at			the facility's legal counsel	
		esident "E" was			contacted the health care	,
					representative and advised he discuss her objections to the	r to
	admitted to 1	the facility on			physician-ordered health care	
	08/01/06 wit	th diagnoses			with the physician himself. Th	
	including by	ut not limited to			facility could not take a positio opposition to that of the health	
	including, but not limited to, seizures, hydrocephalus,				care representative regardless	
					whether the facility agreed wit	
	dysphasia (difficulty swallowing), head injury, and				that decision thus, this is no	
					failure to provide social service II. Identification of and correct	
					actions taken for other resider	l l
	hypertension	1.			having the potential to be affect	cted
					by the alleged deficient practic	e:
					a) All resident records will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/07/2011	
	PROVIDER OR SUPPLIER HANDS HEALTH C SUMMARY S		B. WIN	1850 M	ADDRESS, CITY, STATE, ZIP CODE ATADOR ST IN46970	(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	-	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) audited for any obvious conflic	DATE
	hemoglobin containing p blood cells to from the lun A CBC (Cor Count) done indicated a H of 7.5 with a (normal rang physician's containing the containing physician's containing the containing physician's containing the containing physician's containing physician's containing the containing physician's containing the containing physician's containing the containing physician's containing the containing physician's containing physician's containing the containing physician's cont	' had been equently for low (the iron igment of the red hat carries oxygen gs to body tissues.) mplete Blood on 02/23/11, Hgb (Hemoglobin) reference range ge) of 14.0-18.0. A order, dated dicated, "Transfuse Cs (Packed Red y; may do in a.m" furse's Notes 25 (11:25 a.m.) I name) called & mission for res have consult c			determination of who will be the consenting party for health can decisions. III. Measures take and systemic changes made the ensure the alleged deficient practice does not recur: a) Up admission all residents guardianship / POA status will determined and paperwork reviewed by Social Service. It obvious discrepancies exist, a meeting will be held with familiand resident, and/or legal cout to determine proper guidance. The facility will require resider and families to appoint a surrogate to make health care determinations. b) Upon knochanges in guardianship / PO status, meetings will be called with resident and family; and/or legal counsel to determine who may give consent when reside are unable to do so. A surrog decision-maker will be identified IV. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: a) Social Serwill audit resident guardianship/POA documents a quarterly basis (in coordinat with Care Plan meetings) to discover any obvious changes status and to address timely we families and/or other agencies b) Social Services will report monthly to the QA committee results of this audit for further action by administration and/or adm	ne re re no con con con con con con con con con

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPLE (A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 7/2011	
	PROVIDER OR SUPPLIER		STREE 1850	raddress, city, state, zip co MATADOR ST J, IN46970	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	02/23/11 113	30 (11:30 a.m.)		legal counsel as neede	ed.	
	Also res (PC	OA #1) stated if res				
	needed surge	ery he could not				
	have a blood	transfusion.				
	States it's ag	ainst her (POA #1)				
	religion"					
	02/23/11 6:4	5 p.m.,(.POA #2				
	name) notified-she stated OK.					
	Resident sen Care Facility (related to) I Res is to rec (POA #2 nar stated "OK & please notify res returns to	•				
	Received NO D/C (discontinuo) (at) this x	20 (3:20 p.m.) O (New Order) to tinue) transfusion (time) per (POA DON (Director of				
	_					

003130

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
AND I LAN	or connection	155702	A. BUII B. WIN			04/07/2011
NAME OF I	PROVIDER OR SUPPLIER		D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
				1	ATADOR ST	
	HANDS HEALTH C				IN46970	d ave
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	Nursing) not	tified.				
	02/24/11 160	00 (4:00 p.m.)				
	Spoke c resident's POA (name					
	#1) r/t her de	ecision to stop				
	blood transfi	usion @ this time.				
	(POA #1 nar					
	`	Witness & God				
	would not want her brother to					
		sion. (POA #1)				
	•	ne (POA #1) is the				
		to make decisions				
	5 1	& she does not				
		#2) influencing any				
	decisions	12) illitudicing any				
	decisions					
	 02/25/11 10:	30 a.m. Contacted				
		have been told by				
	` ′	ne) & (POA #2) that				
	`	always been				
		•				
		OA #1) stated she				
		th Witness, did not				
	_	firm that resident is				
	-	stated he had been				
	to "meetings	, II				

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPLI	
		155702	A. BUII B. WIN			04/07/20	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
CARING	HANDS HEALTH C	ARE CENTER		1	ATADOR ST IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	beforeDis	cussed with (POA					
	#1) that deci	sions for resident					
	should act in	his best interest &					
	based on his belief system"						
	A CBC done on 03/10/11,						
	indicated a Hgb of 7.0. A						
	physician's order, dated						
	ĺ	dicated, "Transfuse					
		C's (Packed Red					
	Blood Cells)	·"					
	Review of N	Jurgas Natas					
	indicated:	urses motes					
	muicated.						
	 "03/11/11 19	930 (7:30 p.m.)					
		or 03/11/11 @ 1645					
	(4:45 p.m.).	0					
		ordered if POA					
	agrees & wil	ll consent for					
	•	POA contacted by					
	_	nd Social Services					
	Director. (P	OA #1 name)					
	,	the lab value &					
	updated on r	esident's status.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155702	B. WIN		DDDDGG CITY CTATE ZID CODE	04/07/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST	
CARING	HANDS HEALTH C	ARE CENTER		PERU,	IN46970	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	POA was in	formed that				
	resident has	demonstrated				
	declines in condition. Resident					
	is noted to h	ave pale skin				
	color/nailbeds, increase fatigue,					
	often reuses	to get OOB (out of				
	bed) & refus	ses mealsPOA				
	verbalizes ui	nderstanding of the				
	Hgb as well					
	condition. P	OA continues to				
	refuse the bl	ood transfusion r/t				
	religious bel	iefs. POA did				
	agree to com	ne in to facility this				
	week to asse	ess resident & talk c				
	administrativ	ve staff"				
		ocial Service notes				
		entry on 01/27/11.				
	The next ent	ry indicated:				
		_				
	"03/09/11 ID					
	` -	inary Team: a team				
	•	f staff from various				
	•	to address resident				
	needs) care p	plan meeting held.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPLE (A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 7/2011	
	PROVIDER OR SUPPLIER		STREE 1850	TADDRESS, CITY, STATE, ZIP O MATADOR ST J, IN46970	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		I family invited but				
	not in attendance. He					
	continues D	· ·				
		no life saving				
		event of heart or				
	_	oppage) code status				
		Directives in place				
		s POA is his sister				
	(name of POA #1). Care plans,					
	no changes r	made @ this time."				
	received on 03/21/11, @ down, depre When getting resident kept	ehavior report 03/22/11, dated resident feeling ssed & hopeless. g ready for bed, t asking staff to kill alked to resident r stopped."				
	Designee) lo finding docu (HCP) (Heal	SD (Social Service ooking in overflow ments giving POA of the Care Power of (POA #1 name)				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155702	B. WIN			04/07/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CARING	HANDS HEALTH C	ARE CENTER		1	ATADOR ST IN46970	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	and (POA #2	2 name) secondary				
	from residents mother (name).					
	Both (POA	#1) and (POA #2)				
	notified any	(sic) in agreeance				
	(sic) c forms	no further				
	concerns."					
	The SSD was unavailable for					
	interview. In	iterview with the				
	Administrato	or, on 04/07/11, at				
		ndicated he was				
	· ·	th the issues and				
		ad met with POA				
	_	ot documented the				
		terview with the				
	_	N, on 04/07/11 at				
	•	indicated Resident				
	·					
	"E" had a H					
		d an order for				
		f Hgb dropped to				
		The Corporate				
		d there was no				
		regards to the				
	issue of POA	A#1's religious				

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED
		100702	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	01/01/2	
NAME OF F	PROVIDER OR SUPPLIER				ATADOR ST		
	HANDS HEALTH C			PERU, I	IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	beliefs would	d again need to be					
	addressed.						
	This Federal Tag relates to Complaint #IN00087748.						
3.1-34(a)							
F0272	periodically a com	onduct initially and prehensive, accurate, oducible assessment of nctional capacity.					
A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;							
	Continence; Disease diagnosis Dental and nutritio Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia	s and procedures;					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL 04/07/2	
		155702	B. WIN	_		04/07/20	011
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	HANDS HEALTH C	ARE CENTER			IN46970		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	regarding the addi	tional assessment n the resident assessment		0			
SS=D	Based on re	ecord review and	F0	272	Corrective actions taken for those residents affected by the		05/07/2011
		the facility			alleged deficient practice: Resident C has documentation		
		sure physician's			from the hospital that includes assessment pre-transfusion,		
		e followed and a			during transfusion, and post-transfusion. The hospital	l	
		sessed after the			documentation also includes medications administered per		
	administrat	ion of blood.			order during the transfusion.	Гһе	
	This deficie	ency affected 1			nurse @ LTC included a follow entry in the chart whtat resider	nt C	
	of 3 resider	nts in a sample of			had returned from the hospital and no adverse reactions were		
	3 who had	orders for blood			noted. The nurse also comple a daily skilled note with Vital	eted	
	transfusion	s. (Resident			Signs when resident returned from the hospital. Thus, control	arv	
	"C")				to the survey allegations, thre		
	Finding inc	cludes:			a post-transfusion nursing assessment. II. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: a) All		
	The record	of Resident "C"			residents scheduled for outpat procedures have the potential	tient	
	was review	red on 04/06/11			be affected by the alleged deficient practice. III. Measur		
	at 10:05 a.r	n. Resident "C"			taken and systemic changes made to ensure the alleged		
	was admitte	ed to the facility			deficient practice does not rec	ur:	
	on 01/20/11	l with diagnoses			a) All nursing staff will be re-inserviced on the policy to		
	including, l	out not limited			follow for post out-patient procedures. Additionally, a ne	•w	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. NYNG		(X3) DATE SURVEY COMPLETED 04/07/2011		
AND PLAN	NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		Ì	LDING G STREET A 1850 M		COMPLET 04/07/20	ГED
	Hgb (Hemo containing red blood of oxygen fro body tissue reference range) of 1	pigment of the rells that carries m the lungs to es.) of 7.9 with a range (normal 2.0-15.0).		· · · · · · · · · · · · · · · · · · ·			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPI A. BUILDING B. WING	E CON	NSTRUCTION 00	(X3) DATE: COMPL 04/07/2	ETED	
	PROVIDER OR SUPPLIER		185	0 M <i>A</i>	DDRESS, CITY, STATE, ZIP CODE ATADOR ST N46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	"03/29/11	1430 (2:30 p.m.)					
	Type et (and) Crossmatch						
	•	acked red blood					
	cells. Tran	sfuse two units					
	when avail	able."					
	"03/30/11 I	Lasix 20 mg IV p					
	(after) ea (e	each) unit of					
	blood. Indication: CHF."						
	Review of Nurses Notes indicated: "03/30/11 0130 (1:30 a.m.) Scheduled for blood transfusion 0800 (8:00 a.m.) "0/330/11 1845 6:45 p.m.) Res (resident) returned from hospital from blood transfusion. 0 (no) adverse reactions noted." The Corporate RN was						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL	
		155702	A. BUII B. WIN			04/07/2	011
NAME OF I	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE	ı	
CARING	HANDS HEALTH C	ARE CENTER		1	IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	interviewed	d on 04/06/11 at					
	11:00 a.m.,	in the absence					
	of the DNS	(Director					
	Nursing Se	rvices), in					
	regards to p	post transfusion					
	assessment	s and the					
	administrat	ion of the Lasix.					
	The Corpor	rate RN					
	indicated th	ne facility did					
	not have a	specific policy in					
	regards to p	oost transfusions					
	but the resi	dent should have					
	been assess	sed upon return					
	to the facili	•					
		•					
	The Corpo	orate RN					
	_	ne facility sends					
		an's orders for					
	1 *	s as well as					
		orders, including					
	medication	,					
		then the resident					
	1 Coldelles W	non mo romanit					
	<u> </u>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 7/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	leaves the	facility for the						
	ACF (Acut	te Care Facility:						
	hospital).	The Corporate						
	RN indicat	ed the 2 Lasix						
	doses woul	d have been						
	administer	ed at the ACF						
	and the AC	CF sends						
	documenta	tion to indicate it						
	was given	when the						
	resident ret	turns to the						
	facility. Tl	ne record did not						
	contain any	y information the						
	resident red	ceived the						
	ordered do	ses of Lasix.						
	Review of	the "SKILLED						
	DAILY NU	JRSES NOTE", a						
	focused ch	arting tool for						
	resident's r	eceiving skilled						
	care, indica	ated the						
	resident's V	//S's (Vital						
	Signs: bloc	od pressure,						
	temperatur	e, pulse and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		NSTRUCTION 00	(X3) DATE SI COMPLE	ETED	
		155702	B. WING			04/07/20)11
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CARING	HANDS HEALTH C	ARE CENTER	PERU, IN46970				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	DATE
	respirations	s) were checked				ĺ	•
	prior to leaving for blood						
	transfusion	s and again on					
	the night sh	nift. There was					
	no indication	on the resident					
	was assesse	ed upon return to					
	the facility						
	shift.						
	3.1-31(c)(6						
F0333		ensure that residents are eart medication errors.					
SS=D	Based on re	ecord review and	F033	33	 Corrective actions taken for those residents affected by the 	1	05/07/2011
	interviews,	the facility			alleged deficient practice: Resident C: All physician orde		
	failed to en	sure 1 of 2			have been reviewed and clarifi	ied	
	residents in	a sample of 3			with the attending physician. I Identification of and corrective		
	had receive	ed the correct			actions taken for other residen having the potential to be affect	cted	
	dosage of Levothyroxine(a				by the alleged deficient practic a) All residents have the poter		
	medication	to treat thyroid)			to be affected by the alleged deficient practice. III. Measure	es	
	since admis	ssion on			taken and systemic changes made to ensure the alleged		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THIS I EARLY	or condition	155702	A. BUI B. WIN	LDING IG		04/07/2011
NAME OF P	PROVIDER OR SUPPLIER		D. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	HANDS HEALTH C	ARE CENTER		1	IN46970	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	Finding inc	(Resident "C") cludes: of Resident "C"			deficient practice does not rect a) Nursing staff will be re-inserviced on the following policy and procedures: Physic orders; Transcription of physic orders; Monthly re-cap of physician orders; and Medicati errors. All inservicing will be completed by April 25,2011.	cian ian ion
	was review	red on 04/06/11			Unit managers or designee wil review all physician orders 5 d	
	at 10:05 a.r	n. Resident "C"			per week for accuracy. c) Medication administration audi	
	was admitted to the facility				will be conducted by the DON designee to ensure accuracy a	or
	on 01/10/11	l with diagnoses			completion. IV. How the corrective actions will be	
	including, 1	out not limited			monitored and the QA system	
	to, hypothy	roidism (low			implemented to ensure the alleged deficient practice does	
	thyroid lev	els), COPD			not recur: a) DON or designe will review the medication	
	(Chronic O	bstructive			administration audits weekly x weeks; then monthly x 6 month	ns;
	Pulmonary	Disease), CHF			then quarterly thereafter. Res will be reviewed in monthly QA	
	(Congestiv	e Heart Failure),			committee meetings on-going.	
	pacemaker,	, CRI (Chronic				
	Renal Insu	fficiency),				
	diabetes, hy	yperkalemia				
	(high Potas	sium levels),				
	and hyperte	ension.				
	The record	indicated a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	discrepancy	y in regards to					
	Resident "C" receiving						
	Levothyrox	kine and					
	indicated:						
	A physiciai	n's order					
	"01/10/11 \$	Synthroid (a					
	brand name	e for					
	Levothyroxine) 125 mcg						
	tablet. 1 PC) (Per os: by					
	mouth) dly	(daily)".					
	indicated: '	lated "01/10/11" 'Synthroid 137 aily)" and doses ed:					
	A physician "01/20/11 I	n's order: Levothyroxine					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155702	A. BUIL B. WING			04/07/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
CARING	HANDS HEALTH C	ARE CENTER		1	ATADOR ST IN46970	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
-		(micrograms)				
	oral daily."	` '				
	J					
	"01/20/11"	MARs				
	(Medicatio	n Administration				
	Record): "I	Levothyroxine				
	137 mcg P	O (Per os: by				
	mouth) dai	ly" and doses				
	documente	d as given on:				
	01/22/11					
	01/23/11					
	01/24/11					
	01/25/11					
	On 01/26/1	1 the MARs is				
	noted "see	N.O. (New				
	Order)." Re	eview of the				
	physicians	orders indicated:				
	"01/25/11					
	Clarification	ons:DC				
	Levothyrox	kine 137 mcg.				
	Levothyrox	kine 125 mcg."				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SU COMPLE		
		155702	A. BUII B. WIN			04/07/20	11
NAME OF F	PROVIDER OR SUPPLIER		·		ADDRESS, CITY, STATE, ZIP CODE ATADOR ST		
CARING	HANDS HEALTH C	ARE CENTER			IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	DATE
	Review of	the printed					
	Physicians	Orders for					
	02/2011 ind	dicated:					
	"01/10/11 I	Levothyroxine					
	125 mcg ta	blet. Give 1					
	tablet orall	y once a day."					
	The printed	l order was noted					
	to have a h	andwritten slash					
	through the	e "125 mcg" and					
	a handwritt	ten "137" written					
	above the p	orinted 125 mcg.					
	1	C					
	Review of	the MARs for					
	02/2011 ind	dicated					
	Levothvrox	kine 125 mcg					
	_	e 1 table orally					
	once a day.	•					
	•	tion indicated					
		g dose was given					
	every day i	•					
	every day i	11 UZ/ZU11.					
	Review of	the printed					
	TCVICW UI	me printed					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155702		(X2) MULT A. BUILDII B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Physicians	Orders for						
	03/2011 inc	dicated:						
	"01/20/11 1	Levothyroxine						
	137 mcg ta	blet. Give 1						
	tablet orall	y once a day."						
	Review of	the MARs for						
	03/2011 indicated Resident							
	"C" receive	ed 137 mcg						
	every day i	n 03/2011, as						
	ordered.							
	Review of	the printed						
	Physician (Orders for						
	04/2011 in	dicated:						
	"02/24/11]	Levothyroxine						
	125 mcg ta	blet. Give 1						
	tablet orall	y once a day."						
	Review of	the MARs for						
	04/2011 for	r 04/0/11 through						
	04/06/11 in	dicated Resident						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE SI COMPLE		
		155702	B. WIN			04/07/20	11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST		
CARING	HANDS HEALTH C	ARE CENTER			IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	DATE
	"C" had red	ceived the					
	ordered dos	se of 125 mcg.					
	The medica	ation cart was					
	checked an	d the correct					
	dosage sup	ply was					
	observed for	or Resident "C".					
	All Physici	ans Orders were					
	signed as re	eviewed by 2					
	nurses and	the physician.					
	The Physic	ians Orders for					
	02/2011 we	ere signed by the					
	Consultant	Pharmacist. All					
	MARs revi	ewed were					
	signed as re	eviewed by 2					
	nurses.	•					
	The Corpor	rate Nurse was					
	•	d, in the absence					
	of the DNS						
	Nursing Se						
		11:00 a.m. The					
	otiooiti at	. 11.00 u.iii. 11ic					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	Corporate 1	Nurse indicated						
	being unaware of the							
	discrepanci	ies of						
	Levothyrox	kine dosages						
	since admis	ssion. The						
	Corporate 1	Nurse could not						
	verify the r	nedications were						
	administered as ordered.							
	LPN #2 wa	s queried on						
	04/07/11 at	: 11:00 a.m., in						
	regards to t	the						
	Levothyrox	kine dosage.						
	LPN #2 inc	dicated the						
	correct dos	es were always						
	sent and ad	ministered.						
	LPN #5 wa	as queried on						
		: 11:05 a.m., in						
	regards to t	ŕ						
	•	kine dosage.						
	LPN #5 inc	•						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155702	A. BUII B. WIN			04/07/2	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CARING	HANDS HEALTH C	ARE CENTER			ATADOR ST IN46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	_		, i	IAU			DATE
ı	pharmacy sent the correct dosage.						
l	dosage.						
	 When quer	ied in regards to					
	•	ancy between					
		an's ordered					
		the MARs, both					
		e unaware of the					
		y and could not					
	_	correct dosage					
	was admin						
	•	ebruary or March					
	of 2011.						
	T1 C	4 N T					
	-	rate Nurse, on					
	04/07/11, ii						
	Resident "(
	Levothyrox	kine dosage was					
	to have bee	en 125 mcg since					
	admission.						
	3.1-25(b)(3	3)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMPL	ETED
		155702	B. WIN			04/07/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST		
	HANDS HEALTH C	_			IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0514 SS=D	each resident in a professional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screstate; and progress Based on resident and the resident resident resident resident resident residents in (Resident " The record	the facility sure accurate tion in regards to receiving ordered s for 1 of 1 a sample of 3. C")	F0	514	I. Corrective actions taken for those residents affected by the alleged deficient practice: Resident C: All physician order have been reviewed and clarif with the attending physician. I Identification of and corrective actions taken for other resident having the potential to be affected by the alleged deficient practice. All residents have the potential be affected by the alleged deficient practice. III. Measur taken and systematic changes made to ensure the alleged deficient practice does not recally not an appropriate to the following policy and procedures: Physician orders. Transcription of physician orders; and Medication errors. inservicing will be completed to April 25,2011.b) Unit manager	eers ied II. ats cted ce: II to res ced ; cers; All oy	05/07/2011

155702			LDING	ONSTRUCTION 00	(X3) DATE COMPI 04/07/2	LETED	
NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER			<u>'</u>	1850 M	ADDRESS, CITY, STATE, ZIP CODE ATADOR ST IN46970	•	
CARING (X4) ID PREFIX TAG	at 10:05 a. was admitted on 01/10/1 including, to, hypothy thyroid lever (Chronic Congestive pacemaker Renal Insurdiabetes, he (high Potal and hyperter Review of Resident "physician's "01/25/11. mgl (millill mgl (millill)) at 10:05 a.	m. Resident "C" ted to the facility 1 with diagnoses but not limited yroidism (low rels), COPD Obstructive To Disease), CHF re Heart Failure), r, CRI (Chronic efficiency), yperkalemia ssium levels), ension. the record for C" indicated a s order:Kayexalate 30 iters) X 1" 1. 30 g (grams)		PERU, ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE A	week y and nitored ented ent N or udits uthly x	(X5) COMPLETION DATE

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155702	B. WIN			04/07/201 ²	1	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST			
CARING	HANDS HEALTH C	ARE CENTER		1	IN46970			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	C	(X5) OMPLETION	
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE .	DATE	
	Review of	a MARs						
	(Medication	n Administration						
	Record) for	r 01/20/11						
	through 01	/31/11, did not						
	indicate the	e Kayexalate was						
	given on 01	1/25/11 or						
	01/26/11.							
	"03/15/11 1	l. Kayexalate 30						
	gm po X 1.	"						
	Review of	the MARs for						
	03/2011 die	d not indicate the						
	Kayexalate	was given.						
	The record	indicated a						
	discrepancy	y in regards to						
	Resident "O	C" receiving						
	Levothyrox	kine and						
	indicated:							
	A physician	n's order						
	"01/10/11 Synthroid (a							
	brand name	e for						
	Levothyrox	kine) 125 mcg						
	_	·						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702			(X2) MU) MULTIPLE CONSTRUCTION 00		(X3) DATE S COMPL		
		A. BUII B. WIN			04/07/2011			
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
CARING HANDS HEALTH CARE CENTER					ATADOR ST IN46970			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG	tablet. 1 PO (Per os: by			IAG			DAIL	
	mouth) dly	`						
	inouni) diy	(dairy).						
	A MARs: d	lated "01/10/11"						
	indicated: "	'Synthroid 137						
	mcg dly (da	aily)" and doses						
	administere	ed:						
	01/12/11							
	01/13/11							
	01/14/11							
	01/15/11							
	A physician	n's order:						
	"01/20/11 I	Levothyroxine						
	0.125 mcg	(micrograms)						
	oral daily."	,						
	•							
	"01/20/11"	MARs						
	(Medication	n Administration						
	Record): "I	Levothyroxine						
	137 mcg P0	O (Per os: by						
	mouth) dai	ly" and doses						
	,							

003130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 04/07/2011	
NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER			B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CO ATADOR ST N46970	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	documented as given on:						
	01/22/11						
	01/23/11						
	01/24/11						
	01/25/11						
	On 01/26/1	1 the MARs is					
	noted "see	N.O. (New					
	Order)." Review of the						
	physicians	orders indicated:					
	"01/25/11						
	Clarification	ons:DC					
	Levothyrox	kine 137 mcg.					
	Levothyrox	kine 125 mcg."					
	Review of	•					
	Physicians						
	02/2011 inc						
		Levothyroxine					
	125 mcg tablet. Give 1						
	'	y once a day."					
	_	l order was noted					
	to have a h	andwritten slash					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		ENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		A. BUII B. WIN			04/07/20	011		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST			
CARING	HANDS HEALTH C	ARE CENTER		1	IN46970			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE A:			(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE	
	through the	e "125 mcg" and						
	a handwritt	en "137" written						
	above the p	orinted 125 mcg.						
	Review of	the MARs for						
	02/2011 ind	dicated						
	Levothyrox	kine 125 mcg						
	tablet. Giv	e 1 table orally						
	once a day.	" The						
	documenta	tion indicated						
	the 125 mc	g dose was given						
		•						
	, ,							
	Review of	the printed						
		-						
	03/2011 inc							
		•						
	•							
	• • • • • • •	, J -						
	Review of	the MARs for						
	03/2011 ind	dicated Resident						
	the 125 mc every day in the Review of Physicians 03/2011 incomplete 137 mcg tatablet orally Review of	g dose was given n 02/2011. the printed Orders for dicated: Levothyroxine blet. Give 1 y once a day."						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED	
100702		155702	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/07/2	011
NAME OF PROVIDER OR SUPPLIER					ATADOR ST		
	HANDS HEALTH C			PERU,	IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	"C" receive	ed 137 mcg					
	every day i	n 03/2011, as					
	ordered.						
	Review of	the printed					
	Physician (_					
	04/2011 ind						
		Levothyroxine					
		blet. Give 1					
	_						
	tablet brain	y once a day."					
	Davious of	the MARs for					
		r 04/0/11 through					
		dicated Resident					
	"C" had red						
		se of 125 mcg.					
	The medica	ation cart was					
	checked an	d the correct					
	dosage sup	ply was					
	observed for	or Resident "C".					
	All Physicians Orders were						
	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155702		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		B. WIN			04/07/20	11	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ATADOR ST		
CARING	HANDS HEALTH C	ARE CENTER			IN46970		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	signed as re	eviewed by 2					
	nurses and	the physician.					
	The Physic	ians Orders for					
	02/2011 we	ere signed by the					
	Consultant	Pharmacist. All					
	MARs revi	ewed were					
	signed as re	eviewed by 2					
	nurses.						
	The Corpor	rate Nurse was					
	interviewed	d, in the absence					
	of the DNS	(Director					
	Nursing Se	rvices), on					
	04/06/11 at	11:00 a.m. The					
	Corporate 1	Nurse indicated					
	being unaw	are of the					
	omission of	f the Kayexalate					
	as ordered	•					
	discrepancy	y of the					
		xine orders. The					
	Corporate 1	Nurse could not					
	verify the n	nedications were					
	,						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE SUI COMPLET	LETED	
		155702	B. WIN			04/07/201	1	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE ATADOR ST			
CARING	HANDS HEALTH C	ARE CENTER		1	IN46970			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	DATE	
	administered as ordered.							
	Review of	a Policy and						
	Procedure,	titled						
	"Administr	ative Physician's						
	Orders: 09/	2005" provided						
	by the Cor	porate Nurse on						
	04/07/11 at	8:45 a.m.,						
	indicated:							
	"2. Trans	scribe the order						
	to the MAF	R and/or TAR						
	(Treatment	Administration						
	Record) ex	actly as it was						
	prescribed	by the						
	physician	."						
	- •							
	3.1-50(a)(1) 3.1-50(a)(2)							
		,						